Prior Authorization Request Form for
telotristat (Xermelo)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Xermelo*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **2**
2. Does the patient have a diagnosis of carcinoid syndrome diarrhea?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a decrease from baseline in the amount of average daily bowel movements?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the prescriber agree to continue to assess the patient for severe constipation and abdominal pain and discontinue the medication if either develops?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. While taking Xermelo (telotristat) has the patient had severe constipation or has abdominal pain developed?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[4 December 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: